471-000-5 Instructions for Completing Form DM-5-MR-LTC. "Long Term Care Evaluation for Intermediate Care Facilities for the Mentally Retarded"

Use: Form DM-5-MR-LTC is used to establish level of care for a client admitted to an intermediate care facility for the mentally retarded (ICF/MR).

Number Prepared: Three copies of Form DM-5-MR-LTC are completed (NCR paper).

Completion: Facility staff and local office staff shall complete Form DM-5-MR-LTC within 15 days after the client's admission. It is essential that all pertinent information regarding the client's medical, social, and habilitative needs be included. Form DM-5-MR-LTC is completed as follows:

Refer to 471 NAC 31-ff for use - distribution

Attached Are (upper right corner): The facility shall attach to this form copies of –

- Form DM-5 or A-120
- Interdisciplinary team's pre-admission evaluation and meeting
- Independent QMRP Assessment
- MC-9NF

Resident's Name: Enter the client's name.

Social Security Number: Enter the client's Social Security number.

Date of Birth: Enter the client's date of birth.

Diagnosis Primary: Enter the client's current primary diagnosis. ICD-9-CM codes may be used.

Eligibility Date: Enter the date the client became eligible for Nebraska Medicaid.

Date of Admission: Enter the date the client was admitted to the ICF/MR level of care at this facility. This date requires three conditions be met: The interdisciplinary team agreed to admission, the client physically resides in the facility and the client uses a bed certified for ICF/MR level of care. (See 471 NAC 31-ff).

Diagnosis Secondary: Enter the client's current secondary diagnosis. ICD-9-CM codes may be used.

Local HHS Office: Enter the name of the local HHS office responsible for the client's case.

Date Completed: Enter the date this form was completed at the facility.

Facility Name and Address: Enter the name and address of the facility in which the client resides.

Physician: Enter the name of the client's current attending physician.

Date Last Seen: Enter the date on which the physician last visited the client.

Attending OMRP: Enter the name of the client's OMRP.

1A. Physician's Plan of Care Includes: Check all areas included in the physician's plan of care (physician's orders).

1 B. Team's Plan Also Includes: Check the areas included in the client's pre-admission evaluation by the team. Note: Items already included under the "Physician's Plan of Care" are considered part of the team's pre-admission evaluation but are not repeated) in this section.

2. List Medications: List or attach a list of all prescribed medications and dosages. If medications are ordered PRN, list the frequency the client has required the medication. Attachments may not exceed three pages.

The nurse for the client's living unit shall sign this section. The nurse is responsible for the medical information on this form.

3. Indicate Individual's Needs/Strengths: Check all characteristics which apply to the client and provide further description of the client's skills, behaviors, and characteristics, as appropriate. This section identifies the client's needs and corresponds to the areas addressed in Section 1, Physician's and Team's Plans of Care, and "Current Habilitative Training."

For example, if a client is incontinent, indicate this in the third column. If incontinency is addressed through a toileting schedule, indicate this in the first column. If incontinency is addressed through a formal toileting training program, indicate this in "Current Habilitative Training" (following).

Current Habilitative Training: List the training programs/services currently implemented, including further evaluations or baselines, and the reason for admission; or refer to the client's interdisciplinary team pre-admission evaluation if these items are listed in the evaluation.

On and Off Living Unit: List the current training programs/services provided to the client.

Reason for Admission: Enter a short summary of why this is the best available plan for the client, including the alternatives explored (see 471 NAC 31-ff).

Signatures: The nurse for the client's living area and the QMRP shall sign sections 2 and 3 respectively. The local office worker and the facility staff member shall sign and date the form after completion.

Distribution (see 471 NAC 31-ff):

1. All three copies of Form DM-5-MR-LTC and all attachments are sent to the client's local HHS office;
2. The client's local HHS office shall forward the form and all attachments to the Medicaid ICF/MR Review Team responsible for that facility's reviews;
3. The Medicaid ICF/MR Review Team makes a determination and returns the pink and yellow copies of Form DM-5-MR-LTC to the local office; and
4. The local office retains the pink copy and forwards the yellow copy to the facility.

Retention: The medical review team and the local office shall retain their copies of Form DM-5-MR-LTC for five years after the case is closed. The facility retains its copy of Form DM-5-MR-LTC in the client's record according to the facility's retention schedule.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

ICF/MR CARE EVALUATION
INTERMEDIATE CARE FACILITIES
FOR THE MENTALLY RETARDED
Medicaid Services

__ DM-5 or A-120
__ Team's Pre-admission
__ QMRP Assessment
__ MC9NF

Resident's Name	Social Security Number	Date of Birth
Diagnosis Primary	Eligibility Date	Date of Admission
Diagnosis Secondary	Local HHS Office	Date Completed
Facility Name and Address		
Physician / Date Last Seen	Attending QMRP	

1. A. PHYSICIAN'S PLAN OF CARE INCLUDES:

- ☐ Medications
- ☐ Medical Treatments
- ☐ Diet
- ☐ Dental Evaluation
- ☐ Social Services
- ☐ Psychotropic Medications
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech/Audiology Evaluation/Therapy
- ☐ Activities

B. TEAM'S PLAN ALSO INCLUDES

- ☐ Psychological Evaluation
- ☐ Behavior Management Training
- ☐ Habilitative Training
- ☐ Recreation
- ☐ Social Services Evaluation

2. LIST MEDICATIONS

List Prescribed medications and dosage (if PRN, list frequency the client has required the medication.)

SIGN HERE _____ Signature of Nurse

3. INDICATE INDIVIDUAL'S NEEDS/STRENGTHS (Be descriptive)

- ☐ Skin Breakdown
- ☐ Contractures
- ☐ Choke Prone
- ☐ Suctioning
- ☐ Illeo-Colostomy
- ☐ Recorded Seizure Incidents
  -hard per_; _light per_
- ☐ Toiletting schedule; every_hours
- ☐ Incontinency monitored per schedule
- ☐ Special Skin Care
- ☐ Treatments _____
  _____
- ☐ In Cart
- ☐ Must be Lifted
- ☐ Chairfast
- ☐ Self-mobile in Wheelchair
- ☐ Position Devicing
- ☐ Hearing Impaired
- ☐ Blind/Visually Impaired
- ☐ Bracing
- ☐ Inappropriate/Maladaptive Behavior (describe):
  _____
  _____

Describe skill/level: (independent, physical prompt, messy, uses gestures, simple sentences, etc

Eating _____
Dressing _____
Bathing _____
Toiletting _____
Ambulation _____
Expressive Speech _____
Receptive Lanuage _____

SIGN HERE _____ Name of QMRP

CURRENT HABILITATIVE TRAINING

On and Off Living Unit:

Reason for Admission: (include alternatives explored)

SIGN HERE _____ Facility Personnel Title

DO NOT WRITE IN THIS AREA

SIGN HERE _____ Reviewer's Signature Date

DM-5-MR-LTC Rev. 7/99 (25002)
(Previous version 11/83 should NOT be used)